CHAPTER 75-03-23
PROVISION OF HOME AND COMMUNITY-BASED SERVICES UNDER THE SERVICE PAYMENTS FOR ELDERLY AND DISABLED PROGRAM AND THE MEDICAID WAIVER FOR THE AGED AND DISABLED PROGRAM

75-03-23-01. Definitions. The terms used in this chapter have the same meaning as in North Dakota Century Code chapter 50-06.2, except:

1. "Activities of daily living" means the daily self-care personal activities that include bathing, dressing or undressing, eating or feeding, toileting, continence, transferring in and out of bed or chair or on and off the toilet, and getting around inside.

2. "Adaptive assessment" means an in-home evaluation to identify adaptive devices, equipment, or modifications that enhance the independence and functional capabilities of individuals who may otherwise be unable to remain in their home. An interdisciplinary team conducts the assessment and oversees implementation of recommendations.

3. "Aged" means a person who is sixty-five years of age or older.

4. "Client" means an individual who meets the eligibility requirements to have services reimbursed under this chapter.

5. "Congenital disability" means a disability that exists at birth or shortly thereafter, and is not attributable to a diagnosis of either mental retardation or a closely related condition of mental retardation.

6. "Department" means the North Dakota department of human services, or its designee.

7. "Disability due to trauma" means a disability that results from an injury or assault to the body by an external force.

8. "Disability that is acquired" means a disability that results from an assault that occurs internally within the body.

9. "Disabled" means a person under age sixty-five who has a congenital disability, a disability due to trauma, or an acquired disability.

10. "Functional assessment" means an evaluation process based on a person's ability to perform self-care activities and other skills necessary for independent living.

11. "Functional impairment" means the inability to perform, either by oneself or with adaptive aids or with human help, the specific activities or instrumental activities of daily living.

12. "Home and community-based services" means the array of services under the SPED program and medicaid waiver defined in the comprehensive human service plan and the other services the department determines to be essential and appropriate to sustain individuals in their homes and in their communities, and to delay or prevent institutional care.

13. "Instrumental activities of daily living" means tasks requiring cognitive ability or physical ability, or both. Tasks include preparing meals, shopping, managing money, housework, laundry, taking medicine, transportation, using the telephone, and mobility outside the home.

14. "Medicaid waiver program" means the federal medicaid waiver for the aged and disabled program, as defined in subpart G of 42 CFR 441, under which the department is authorized to provide specific home and community-based services to aged and disabled persons who are at risk of being institutionalized.

15. "Service payment" means the payment issued by the department to a qualified service provider for the provision of authorized home and community-based services to eligible aged and disabled persons.

16. "SPED program" means "service payments for elderly and disabled program", a state program which authorizes the department to reimburse qualified service providers for the provision of covered home and community-based services to eligible aged and disabled persons.

17. "SPED program pool" means the list maintained by the aging services division of the department that contains the names of those individuals who meet the eligibility criteria to receive services under the SPED program and for whom SPED program funding is available when the

individual's name is transferred from the SPED program pool to SPED program active status.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-02. Eligibility criteria.

1. An applicant shall be entered in the SPED program pool before service payments may be authorized. The department shall allow entry into the SPED program pool to occur:

   a. When the county social service board of the county where the applicant resides or will receive services submits a form in the manner prescribed by the department; or

   b. When the applicant meets the special circumstances provided in section 75-03-23-03.

2. An applicant's resources must not exceed fifty thousand dollars for the applicant to be eligible for services under the SPED program. For purposes of this section, resources are cash or similar assets that can be readily converted to cash and include residences owned by the applicant other than the applicant's primary residence.

3. An applicant eighteen years of age or older is eligible for the SPED program pool if:

   a. The applicant has functional impairment in activities of daily living or in instrumental activities of daily living as specified by the department in policies and procedures to indicate applicant eligibility;

   b. The applicant's functional impairment has lasted, or can be expected to last, three months or more;

   c. The applicant's functional impairment is not the result of a mental illness or a condition of mental retardation, or a closely related condition;

   d. The applicant is living in a housing arrangement commonly considered a private family dwelling and not in an institution, dormitory, or congregate housing arrangement;

   e. The applicant is not eligible for services under the medicaid waiver program.

f. The applicant would receive one or more of the covered services in accord with department policies and procedures for the specific service;

g. The applicant agrees to the plan of care developed for the provision of home and community-based services; and

h. The applicant is not responsible for one hundred percent of the cost of the covered service provided, in accord with the human service plan sliding fee scale based on family size and income.

4. An applicant under eighteen years of age is eligible for the SPED program pool if the applicant is determined to need nursing facility level of care as provided for in section 75-02-02-09 and the applicant's care need is not the result of a mental illness or the condition of mental retardation, or a closely related condition.

5. Applicants under eighteen years of age are subject to the following limitations or requirements in addition to the eligibility criteria in subsection 3.

   a. An applicant is not eligible for service payments unless care provided to the applicant by the applicant's parent or the applicant's spouse is provided under family home care.

   b. An applicant is eligible for service payments if the caregiver:

      (1) Had to terminate outside employment to care for the applicant;

      (2) Needs to supplement the family income by outside employment if the SPED payments were not available; or

      (3) Would be dependent on county poor relief for support with the service payment.

6. All applicants must be capable of directing self-care or have a legally responsible party to act in the applicant's behalf.

7. An applicant is not eligible for service payments if the care provided is court ordered.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-04(3)

75-03-23-03. Eligibility determination - Authorization of services.

1. The department shall provide written notice to the county social service board of the county where the applicant receives services as of the effective date of the applicant's eligibility for services funded under the SPED program.

2. A person transferred to active status from the SPED program pool shall continue to meet the eligibility criteria of section 75-03-23-02 in order to remain eligible for services funded under the SPED program.

3. The county social service board's home and community-based services case manager is responsible for:

   a. Verifying that the person transferred to active status continues to meet the eligibility criteria for entry into the SPED program pool;

   b. Developing a care plan; and

   c. Authorizing covered services in accord with department policies and procedures.

4. A recipient of services under the medicaid waiver program, who becomes ineligible for the medicaid waiver program because evaluation shows that the recipient no longer requires a nursing facility level of care, shall not have to go through the SPED program pool to receive services through the SPED program as long as all eligibility criteria in subsections 2 through 5 of section 75-03-23-02 are met.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-04. Eligibility criteria for medicaid waiver program. An applicant is eligible to receive services funded by the medicaid waiver program if:

1. The applicant is either aged or disabled, and, if disabled:

   a. The disability must not be the result of mental illness as the primary diagnosis or the result of mental retardation, or a closely related condition; and

   b. The disability must meet the social security administration's definition of disability.

2. The applicant is receiving medicaid;

3. The applicant is evaluated to be in need of a nursing facility level of care;

4. The applicant's needs may be met by one or more of the covered services, as determined by an assessment conducted in accord with department policies and procedures;

5. The applicant's service provider is not the applicant's spouse, or, if the applicant is less than eighteen years old, the applicant's service provider is not the applicant's parent;

6. The applicant agrees to accept services provided under the medicaid waiver program instead of nursing home care; and

7. The applicant agrees to the plan of care developed for the provision of home and community-based services.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5), 50-06.2-03(6)

75-03-23-05. Services covered under the SPED program - Programmatic criteria. The following categories of services are covered under the SPED program and may be provided to a client.

1. Adult day care services may be provided to a client:

   a. Who requires assistance in activities of daily living or instrumental activities of daily living;

   b. Who is able to function in an ambulatory care setting;

   c. Who is able to participate in group activities; and

   d. If the client does not live alone, the client's primary caregiver will benefit from the temporary relief of care giving.

2. Adult foster care may be provided to a client eighteen years of age or older:

   a. Who requires care or supervision;

   b. Who would benefit from a family environment; and

   c. Whose required care does not exceed the capability of the foster care provider.

   Care must be provided in a licensed adult foster care home. SPED program service payments may not be used to pay room and board costs for adult foster care.

3. Chore services may be provided to a client who is unable to perform intermittent or occasional home tasks such as heavy housework and periodic cleaning, minor home repair, and walk maintenance. The task must be the responsibility of the client and not the responsibility of the landlord. Chore services may also be used to install bathroom safety rails or other equipment that enables self-care.

4. Family home care services may be provided to a client:

   a. Who lives in the same residence as the care provider on a twenty-four-hour basis;

   b. Who agrees to the provision of services by the care provider; and

   c. Who is the spouse of the care provider or by one of the following relatives, or the current or former spouse of one of the following relatives of the client: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew.

5. Home and community-based services case management services may be provided to a client who needs a comprehensive assessment and the coordination of cost-effective delivery issues. The case management services must be provided by a licensed social worker in accord with North Dakota Century Code section 43-41-04.

6. Home health aide services may be provided to a client who needs nonprofessional help with personal care tasks or activities on an intermittent or occasional basis.

7. Homemaker services may be provided to a client who needs assistance with environmental maintenance tasks including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. Shopping assistance may be provided only if at least one other task is performed and no other shopping assistance is available through informal networks or other community providers.

8. Nonmedical transportation services may be provided to clients who are unable to provide their own transportation and need transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

9. Personal attendant care services, which must be provided in the client's home, may be provided to a client:

   a. Who is at least eighteen years of age;

b. Who lives alone or is alone due to the employment of the primary caregiver or the incapacity of other household members; and

c. Who needs nonprofessional care or supervision on a daily basis.

10. Respite care services may be provided to a client in the client's home, in the provider's home, in a nursing home, or in a hospital, if:

a. The client has a full-time primary caregiver;

b. The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

c. The primary caregiver's need for the relief is intermittent or occasional; and

d. The primary caregiver's need for relief is not due to the primary caregiver's employment.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-06. Services covered under the medicaid waiver program - Programmatic criteria. The following services are covered under the medicaid waiver program and may be provided to a client.

1. Adult day care services may be provided to a client:

a. Who requires assistance in activities of daily living or instrumental activities of daily living;

b. Who is able to function in an ambulatory care setting;

c. Who is able to participate in group activities; and

d. Whose primary caregiver, who shall reside with the client, will benefit from the temporary relief of care giving.

2. Chore services may be provided to a client who is unable to perform intermittent or occasional home tasks, including heavy housework and periodic cleaning, minor home repair, and walk maintenance. The task must be the responsibility of the client and not the responsibility of the landlord. Chore services may also be used to install bathroom safety rails or other equipment that enables self-care.

3. Home and community-based services case management services may be provided to a client who needs a comprehensive assessment and the coordination of cost-effective delivery of services. The case management services must be provided by a licensed social worker in accord with North Dakota Century Code section 43-41-04.

4. Home health aide services may be provided to a client who needs nonprofessional help with personal care tasks or activities or an intermittent or occasional basis.

5. Homemaker services may be provided to a client who needs assistance with environmental maintenance tasks, including light housekeeping, laundry, meal planning and preparation, and shopping on an intermittent or occasional basis. Shopping assistance may be provided only if at least one other task is performed and no other shopping assistance is available through informal networks or other community providers.

6. Nonmedical transportation services may be provided to clients who are unable to provide their own transportation and need transportation to access essential community services such as grocery stores or pharmacies. "Nonmedical transportation services" are transportation services not related to the receipt of medical care.

7. Personal attendant care services, including adult foster care, may be provided to a client:

   a. Who is at least eighteen years of age;

   b. Who lives alone or is alone due to the employment of the primary caregiver or the incapacity of other household members; and

   c. Who needs nonprofessional care or supervision on a daily basis.

   Personal attendant care may be provided in the client's home or, if the client would benefit from a family environment, in the provider's home. If the care is provided in the provider's home, the provider must be licensed in accord with chapter 75-03-22. Medicaid waiver payments may not be used to pay room and board costs for adult foster care.

8. Respite care services may be provided to a client in the client's home, in the provider's home, in a nursing home, or in a hospital, if:

   a. The client has a full-time primary caregiver;

   b. The client needs a qualified caregiver or it would be inappropriate to use an unqualified caregiver in the absence of the primary caregiver;

c. The primary caregiver's need for the relief is intermittent or occasional; and

d. The primary caregiver's need for relief is not due to the primary caregiver's employment.

9. Specialized equipment and supplies may be provided to a client who is at least eighteen years of age, if:

a. The specialized item's need is based on an adaptive assessment;

b. The specialized item directly benefits the client's ability to perform personal care or household tasks;

c. The specialized item will reduce the intensity or frequency of human assistance required to meet the client care needs;

d. The specialized item is necessary to prevent the client's institutionalization;

e. The specialized item is not available under the medicaid state plan; and

f. The client is motivated to use the specialized item.

10. Training for family caregivers may be provided to family members who provide care to a client.

a. The client shall be at least eighteen years of age.

b. The client and family member receiving the training shall be related by blood or marriage.

c. The family member shall provide primary care to the client.

d. The training must directly benefit the family member's ability to meet the care needs of the client.

e. The family member is motivated to learn and perform care techniques and therapies.

11. At a cost that is proportional to the benefit outcome, environmental modification may be provided to a client:

a. Who owns the home to be modified and owned it prior to making application for the modification;

b. Whose home is structurally sound;

c. For whom the modification will enable the client to complete the client's own personal care or to receive care; and

d. When no alternative community resource, such as housing grants, is available.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-01(3), 50-06.2-03(5)

75-03-23-07. Qualified service provider standards and agreements.

1. The individual or agency seeking designation as a qualified service provider shall complete and return the applicable forms supplied by the department in the form and manner prescribed. The qualified service provider shall meet all licensure and certification requirements applicable under state or federal law and departmental standards.

2. All providers shall:

   a. Have the basic ability to read, write, and verbally communicate;

   b. Not have been convicted of a offense in the last three years that has a direct bearing on the individual's fitness to be a direct care provider;

   c. Not have infectious or contagious disease and shall be physically capable of performing the service; and

   d. Practice confidentiality; and

   e. Participate in at least one hour of continuing skill development for every two hundred hours of service or care provided, up to a maximum of ten hours per year.

3. Evidence of competency must be provided in:

   a. The generally accepted procedure for infection control and proper handwashing methods;

   b. The generally accepted procedure for handling and disposing of body fluids;

   c. The generally accepted procedure for tub, shower, and bed bathing techniques;

   d. The generally accepted procedure for hair care techniques, sink shampoo, and shaving;

e. The generally accepted procedure for oral hygiene techniques of brushing teeth and cleaning dentures;

f. The generally accepted procedure for caring for an incontinent resident;

g. The generally accepted procedure for feeding or assisting a resident with eating;

h. The generally accepted procedure for basic meal planning and preparation;

i. The generally accepted procedure for assisting a resident with the self-administration of medications;

j. The generally accepted procedure for changing a dressing on noninfected sores;

k. The generally accepted procedures and techniques, including dusting, vacuuming, floor care, garbage removal, changing linens, and other similar tasks, for maintaining a kitchen, bathroom, and other rooms used by residents in a clean and safe condition;

l. The generally accepted procedures in laundry techniques, including mending, washing, drying, folding, putting away ironing, and related work;

m. The generally accepted procedure for assisting a resident with bill paying and balancing a check book;

n. The generally accepted procedure for dressing and undressing a resident;

o. The generally accepted procedure for assisting with toileting;

p. The generally accepted procedure for routine eye care;

q. The generally accepted procedure for proper care of nails and feet;

r. The generally accepted procedure for caring for skin, including giving a back rub;

s. The generally accepted procedure for turning and positioning a resident in bed;

t. The generally accepted procedure for transfer using a belt, standard sit, or bed to wheelchair;

u. The generally accepted procedure for assisting a resident with ambulation; and

v. The generally accepted procedure for making wrinkle-free beds.

4. A physician, registered nurse, occupational therapist, physical therapist, or other person with a professional degree in specialized areas of in-home care shall verify, in writing, on forms furnished by the department, that a provider is competent to perform procedures specified in subsection 3. Verification that a provider is competent to perform a procedure is evidence of competence with respect to that procedure.

5. Competence may be demonstrated in the following ways:

a. A demonstration of the procedure being performed;

b. A detailed verbal explanation of the procedure; or

c. A detailed written explanation of the procedure.

6. The department shall notify the individual or the agency of its decision on designation as a qualified service provider. If the decision is not favorable, the individual or agency shall be notified why the requirements for designation as a qualified service provider were not met. If the decision is favorable, the individual's or the agency's name shall be added to the qualified service provider list for each identified county, along with the specific services, endorsements, and unit rates.

7. The county social service board shall maintain a list of qualified service providers. Once the client's need for services has been determined, the client selects a provider from the list and the county social service board issues an authorization to provide services to the selected qualified service provider.

8. A service payment may be issued only to a qualified service provider who bills the department after the delivery of authorized services.

History: Effective June 1, 1995; amended effective March 1, 1997.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-08. Termination of qualified service provider status. The department may remove a qualified service provider from a county social service board's list of approved providers if the qualified service provider:

1. Voluntarily withdraws from participation as a qualified service provider;

2. Is not in compliance with applicable state laws, state regulations, or program issuances concerning providers;

3. Is not in compliance with the terms of the provider agreement;

4. Is not in compliance with the provider certification terms on the claims submitted for payment;

5. Has assigned or otherwise transferred the right to payment of a program claim, except as provided in 42 U.S.C. 1396a(a)(32);

6. Has demonstrated a pattern of submitting inaccurate billings or cost reports;

7. Has demonstrated a pattern of submitting billings for services not covered under the SPED program or the medicaid waiver program;

8. Has been debarred or the provider's license or certificate to practice in the provider's profession or to conduct business has been suspended or terminated;

9. Has delivered goods, supplies, or services that are of an inferior quality or are harmful to individuals;

10. Is insolvent; or

11. Has been removed from a county's list of approved providers for other good cause.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-09. Payment under the SPED program and the medicaid waiver program.

1. The department shall establish provider rates for each home and community-based service in accord with a procedure that factors in:

   a. Whether a provider is an individual or an agency;

   b. The range of rates submitted by various providers; and

   c. The average cost of county social service boards in delivering certain services.

2. The rate for a specific qualified service provider is established at the time the provider agreement is signed.

3. A request for a rate decrease must be accepted at any time and granted when the department receives a written request for the decrease from the qualified service provider.

4. A request for a rate increase must be granted in full or in part, or denied, when the department receives a written request for the rate increase from the qualified service provider.

5. The department shall determine the maximum amount allowable per client each month for a specific service.

6. The department shall establish the aggregate maximum amount allowable per client each month for all services. The aggregate maximum amount per client depends on whether the client is receiving services under the SPED program, under the medicaid waiver program, or under both programs.

7. The department or designee may grant approval to exceed the monthly service program maximum for a specific client who is only receiving SPED funds and no medicaid funds if:

   a. The client has a special or unique circumstance;

   b. The SPED client is not eligible for medicaid; and

   c. The need for additional service program funds will not initially exceed three months.

   Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

8. The department may grant approval to exceed the monthly service program maximum for a specific client who is receiving SPED funds and medicaid funds or only medicaid funds if:

   a. The client has a special or unique circumstance;

   b. The need for additional service program funds does not exceed three months; and

   c. The total need for service program funds per month must not exceed the aggregate monthly maximum amount for a client who receives services under both the SPED program and the medicaid waiver program, excluding home and community-based services case management.

   Under emergency conditions, the department may grant a one-time extension not to exceed an additional three months.

9. The county social service board shall notify the client of the department's determination. If the department denies the request to exceed the monthly aggregate maximum, the county social service board shall inform the client in writing the reason for the denial, the right to appeal, and the appeal process, as provided for in chapter 75-01-03.

10. Providers are limited to a maximum of two hundred hours of care per month, unless an emergency or unusual circumstances is determined by the county social service board. The county social service board shall submit a written request to exceed the monthly aggregate maximum or the monthly service maximum before authorizing any service in excess of the maximum monthly amount. The department shall provide written notice of its decision to the county social service board and the qualified service provider.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5)

75-03-23-10. Department to recover funds upon establishment of noncompliance. A qualified service provider shall not submit a claim for payment or receive service payments for services that have not been delivered in accord with department policies and procedures. The department shall recover all payments received by a qualified service provider who fails to deliver the services in accord with the provider agreement or department policy and procedure.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6)

75-03-23-11. Denial and termination of services - Appeal.

1. A person who is determined to be ineligible for covered services or becomes ineligible while receiving services shall be informed in writing of the denial, the reasons for the denial, the right to appeal, and the appeal process as provided in chapter 75-01-03.

2. Clients shall receive ten calendar days' notice before termination of services occurs. The ten-day notice does not apply if the client enters a basic care facility, a nursing facility, or requests termination of services.

3. An applicant denied services or a client terminated from services should be given an appropriate referral to other public or private service providers and should be assisted in finding other resources.

4. For denial or termination of services, a review of the decision by the county social service board director or the designee may be requested. A request for review does not change the time within which the request for an appeal hearing must be filed.

5. Termination of all SPED program and medicaid waiver program services or immediate termination of a specific service must be considered by the department through its aging services division when continued service to the client presents an immediate threat to the health or safety of the client, the provider of services, or others. Examples of client behaviors that could lead to termination of services include physical abuse of the provider or contraindicated practices, like smoking while using oxygen. The county social service board shall inform the client in writing the reason for the termination, the right to appeal, and the appeal process, as provided for in chapter 75-01-03.

History: Effective June 1, 1995.
General Authority: NDCC 50-06.2-03(6)
Law Implemented: NDCC 50-06.2-03(5), 50-06.2-03(6), 50-06.2-04(1), 50-06.2-04(3)